SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

Paediatric Questionnaire
Pre-Surgical Patient Information Form

PLEASE USE A PEN, PREFERABLY BLACK INK, TO FILL OUT THIS FORM.
To be completed by patient or designate.

Print child's name: _____ Date: _____(dd/mm/yyyy)

English speaking ☐ Yes ☐ No
If no, language spoken: _____
Accompanied by:_____
Any visitor restrictions? _____

Able to read English: ☐ Yes ☐ No
Interpreter required: ☐ Yes ☐ No
Relationship:_____

Glasses/contact lenses: ☐Yes ☐ No
Hearing aid: ☐ Yes ☐ No ☐ Right ☐Left ☐Both
Do he/she require assistance walking? ☐Yes ☐No ☐ Cane ☐ Walker ☐ Wheelchair

For day surgery patients only (if your child is going home the same day his/her surgery is done):
Their surgery will be cancelled if you do not have a responsible adult to provide transportation home and someone to remain with your child overnight.
Have you arranged for a responsible adult to pick your child up and stay with them overnight? ☐ Yes ☐ No

PREADMIT : P: _____ BP: _____ O_2 Sats _____ BG (am of visit): _____

DAY SURGERY: P: _____ BP: _____ O_2 Sats _____ BG: _____

Instructions: Please circle 'Yes' or 'No' for each question. Fill in blanks for details. The nurse will review the questionnaire with you during your appointment.

	HEART and ARTERIES **Does your child have or have ever had?**	**NURSING ASSESSMENT**
YES NO	CONGENITAL HEART ABNORMALITY/BIRTH DEFECT? Corrected? YES NO	
YES NO	RHEUMATIC FEVER?	
YES NO	ABNORMAL HEART VALVES or MURMUR?	
YES NO	BLOOD DISORDER?	
YES NO	BLOOD CLOT IN LEG OR LUNGS?	
	DELIVERY INFORMATION **If child under two or born premature**	
	Type of delivery: Vaginal C/section How many weeks? _____ Complications: _____ Birth Weight: _____	

Paediatric Questionnaire
Pre-Surgical Patient Information Form

	LUNGS/RESPIRATORY Does your child have or ever had?	
YES NO	ASTHMA (wheezing)?	
YES NO	CROUP?	
YES NO	SLEEP APNEA? If so, do they use CPAP? **YES NO** _____**cm H_2O**	
YES NO	recent COUGH/ COLD/ RESPIRATORY INFECTION?	
YES NO	REACTIVE AIRWAY DISEASE?	
YES NO	BRONCHITIS OR BRONCHIOLITIS?	
YES NO	SHORTNESS OF BREATH with minimal activity?	
	GENERAL **Does your child have or have ever had?**	**NURSING ASSESSMENT**
YES NO	DIABETES? Since when? _____ Diet only Pills Insulin BG average _____	
YES NO	HEARTBURN/ GASTROESOPHAGEAL REFLUX?	
YES NO	THRYOID PROBLEMS? Since when?	
YES NO	KIDNEY DISEASE?	
YES NO	JUVENILE ARTHRITIS?	
YES NO	Any WOUNDS/ULCERS that are being treated? Homecare? **YES NO**	
YES NO	CANCER? Type: _____ Year_____ Radiation? Chemotherapy?	
YES NO	MENTAL HEALTH PROBLEMS?	
YES NO	SEIZURES? Most recent seizure: _____	
YES NO	HEPATITIS/JAUNDICE?	
YES NO	MOTOR/COGNITIVE DELAY?	
YES NO	TOILET TRAINED? (if under 5)	
YES NO	BOTTLE FEEDING? BREASTFEEDING?	

Paediatric Questionnaire
Pre-Surgical Patient Information Form

	ANESTHETIC HISTORY	
YES NO	Has your child or your family had any unusual reaction to anesthesia?	
YES NO	Does your child or your family have a history of MALIGNANT HYPERTHERMIA?	
YES NO	Has your child taken oral STEROIDS (Prednisone) in the past 6 months?	
YES NO	History of NEUROMUSCULAR DISEASE	
YES NO	Does your child have a LATEX allergy?	
YES NO	Teeth LOOSE or CAPPED?	
YES NO	BRACES/RETAINERS?	
	Child's response to ANXITEY:	

HOSPITALIZATION IN LAST 5 YEARS		Major Surgical History	
Reason	**Date**	**Reason**	**Date**

Is there anything else you would like to add?

Patient signature: _____
OR
Designate signature: _____ **Relationship:** _____

Reviewed by:
Nurse signature:_____ **Date:** _____
(dd/mm/yyyy)

Paediatric Questionnaire
Pre-Surgical Patient Information Form

NURSING NOTES